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2001STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LICS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.		07914		II. CERTII	FICATION BY AUTHORIZED FACILITY OFFICER			
	Facility Name: Covenant Home of Chicago Address: 2725 West Foster Avenue Chicago Number City County: Cook		60625 Zip Code	State of and cert are true,	nave examined the contents of the accompanying report to the of Illinois, for the period from 02/01/00 to 01/31/01 certify to the best of my knowledge and belief that the said contents rue, accurate and complete statements in accordance with cable instructions. Declaration of preparer (other than provider)			
	Telephone Number: (312) 878-8200 IDPA ID Number: 36-30959-32001		is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.					
	Date of Initial License for Current Owners: Type of Ownership:	7/1/1890		Officer or	(Signed) (Date) (Type or Print Name) Richard W. Olson			
	XX VOLUNTARY,NON-PROFIT XX Charitable Corp. Trust	PROPRIETARY Individual Partnership	GOVERNMENTAL State County		(Title) Vice President - Finance (Signed) See attached Accountants Report			
	IRS Exemption Code 501(C)(3)	Corporation "Sub-S" Corp. Limited Liability Co. Trust Other	Other	Preparer	(Print Name and Title) (Firm Name & Address) (Date) (Control Date) (Control Date) (Date) (Date) (Date)			
	In the event there are further questions about Name: Barry C. Scutillo, CPA	t this report, please contact: Telephone Number: (954) 721		(Telephone) (954) 721-5222 Fax ‡ (954) 722-6692 MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630				

STATE OF ILLINOIS Page 2

Facil	ity Name & ID Numb	oer Covenant Ho	me of Chicago			# 0007914 Report Period Beginning: 02/01/00 Ending: 01/31/01						
	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?					
	A. Licensure/c	certification level(s) of	f care; enter numbe	r of beds/bed days,			(Do not include bed-hold days in Section B.)					
	(must agree	with license). Date of	change in licensed b	oeds	N/A							
							E. List all services provided by your facility for non-patients.					
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)					
							None					
	Beds at				Licensed							
	Beginning of	Licensu	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes					
	Report Period	Level of	Care	Report Period	Report Period		· · · · · · · · · · · · · · · · · · ·					
	•			1 ^	1 ^		G. Do pages 3 & 4 include expenses for services or					
1	52	Skilled (SNI	F)	52	19,032	1	investments not directly related to patient care?					
2		Skilled Pedi	atric (SNF/PED)			2	YES XX NO					
3		Intermediat	e (ICF)			3	<u> </u>					
4		Intermediat	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?					
5		Sheltered Care (SC)				5	YES NO XX					
6		ICF/DD 16 or Less				6						
							I. On what date did you start providing long term care at this location?					
7	52	TOTALS		52	19,032	7	Date started <u>07/01/1890</u>					
							J. Was the facility purchased or leased after January 1, 1978?					
	B. Census-For	the entire report per					YES Date NO XX					
	1	2	3	4	5							
	Level of Care		by Level of Care an	d Primary Source of	Payment	_	K. Was the facility certified for Medicare during the reporting year?					
		Public Aid					YES XX NO If YES, enter number					
_		Recipient	Private Pay	Other	Total	+	of beds certified 6 and days of care provided 1,203					
	SNF	5,943	10,153	1,203	17,299	8						
	SNF/PED					9	Medicare Intermediary AdminaStar Federal, Inc.					
	ICF					10	W. A GGOVINITING DAGGE					
_	ICF/DD					11	IV. ACCOUNTING BASIS					
	SC PRINCE					12	MODIFIED					
13	DD 16 OR LESS					13	ACCRUAL XX CASH* CASH*					
14	TOTALS	5,943	10,153	1,203	17,299	14	Is your fiscal year identical to your tax year? YES XX NO					
	C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.89%					Tax Year: 01/31/01 Fiscal Year: 01/31/01 * All facilities other than governmental must report on the accrual basis.						

STATE (F ILL	INOIS				Page 3
	#	0007014	Danart Pariod Reginning	2/1/2000	Ending	1/31/2001

		Covenant Hom			#	0007914	Report Period	l Beginning:	2/1/2000	Ending:	1/31/2001	_
	V. COST CENTER EXPENSES (through	ghout the report	, please round	<u>to the nearest d</u>	ollar)	ъ .	D 1 '6' 1 1	<u> </u>	4 11 / 1	EOD OHE	LICE ONLY	
	0 4 5		osts Per Gener		TF ()	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total		4.0	
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	114,004	10,126	16,178	140,308		140,308		140,308			1
2	Food Purchase		102,863		102,863		102,863		102,863			2
3	Housekeeping	54,714	6,851		61,565		61,565		61,565			3
4	Laundry	4,966	1,557	57,053	63,576		63,576		63,576			4
5	Heat and Other Utilities			37,345	37,345		37,345		37,345			5
6	Maintenance	9,206	372	1,423	11,001		11,001	224,126	235,127			6
7	Other (specify):*			4,020	4,020		4,020		4,020			7
8	TOTAL General Services	182,890	121,769	116,019	420,678		420,678	224,126	644,804			8
	B. Health Care and Programs											
9	Medical Director			5,850	5,850		5,850		5,850			9
10	Nursing and Medical Records	890,621	86,234	17,183	994,038		994,038		994,038			10
10a	Therapy	41,832	1,156	49,692	92,680		92,680		92,680			10:
11	Activities	47,673	2,005	14,462	64,140		64,140	(48)	64,092			11
12	Social Services	22,478	107	760	23,345		23,345		23,345			12
13	Nurse Aide Training											13
	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,002,604	89,502	87,947	1,180,053		1,180,053	(48)	1,180,005			16
	C. General Administration							ì				
17	Administrative	48,352		61,212	109,564	(5,577)	103,987	89,507	193,494			17
18	Directors Fees											18
19	Professional Services			45,330	45,330		45,330		45,330			19
20	Dues, Fees, Subscriptions & Promotions			6,381	6,381		6,381	(241)	6,140			20
21	Clerical & General Office Expenses	33,383	1,483	17,553	52,419		52,419	12,552	64,971			21
22	Employee Benefits & Payroll Taxes	·		248,335	248,335	5,577	253,912	·	253,912			22
23	Inservice Training & Education			·	·	·	·					23
24	Travel and Seminar			4,364	4,364		4,364	(3,094)	1,270			24
25	Other Admin. Staff Transportation			ŕ				` ' '	<u> </u>			25
26	Insurance-Prop.Liab.Malpractice			8,196	8,196		8,196		8,196			26
27	Other (specify):*								•			27
28	TOTAL General Administration	81,735	1,483	391,371	474,589		474,589	98,724	573,313			28
20	TOTAL Operating Expense	1 267 220	212.754	595,337	2 075 220		2.075.220	222 802	2 200 122			20
29	(sum of lines 8, 16 & 28) *Attach a schedule if more than one typ	1,267,229	212,754		2,075,320		2,075,320	322,802	2,398,122			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

Facility Name & ID Number

			Cost Per Gener	ral Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHE	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			45,141	45,141		45,141	55,281	100,422			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			21,018	21,018		21,018	(2,147)	18,871			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			169,000	169,000		169,000	(169,000)				34
35	Rent-Equipment & Vehicles			1,870	1,870		1,870	(1,050)	820			35
36	Other (specify):*											36
37	TOTAL Ownership			237,029	237,029		237,029	(116,916)	120,113			37
	Ancillary Expense											4
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		36,888	1,260	38,148		38,148		38,148			39
40	Barber and Beauty Shops			5,795	5,795		5,795		5,795			40
41	Coffee and Gift Shops		34		34		34		34			41
42	Provider Participation Fee							28,548	28,548			42
43	Other (specify):*	8,195	14	47,011	55,220		55,220	(55,220)				43
44	TOTAL Special Cost Centers	8,195	36,936	54,066	99,197		99,197	(26,672)	72,525			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,275,424	249,690	886,432	2,411,546		2,411,546	179,214	2,590,760			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

02/01/00

Page 5 01/31/01

4

Ending:

VI. ADJUSTMENT DETAIL

0007914 **Report Period Beginning:** A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	i z below, i	Amount	2 Refer- ence	OHF USE ONLY	
1	Day Care	\$			\$	1
2	Other Care for Outpatients					2
3	Governmental Sponsored Special Programs					3
4	Non-Patient Meals					4
5	Telephone, TV & Radio in Resident Rooms					5
6	Rented Facility Space					6
7	Sale of Supplies to Non-Patients					7
8	Laundry for Non-Patients					8
9	Non-Straightline Depreciation		(29,745)	30		9
10	Interest and Other Investment Income		(2,147)	32		10
11	Discounts, Allowances, Rebates & Refunds					11
12	Non-Working Officer's or Owner's Salary					12
13	Sales Tax					13
14	Non-Care Related Interest					14
15	Non-Care Related Owner's Transactions					15
	Personal Expenses (Including Transportation)					16
	Non-Care Related Fees					17
18	Fines and Penalties					18
	Entertainment					19
	Contributions					20
	Owner or Key-Man Insurance					21
22	Special Legal Fees & Legal Retainers					22
23	Malpractice Insurance for Individuals					23
24	Bad Debt					24
25	Fund Raising, Advertising and Promotional					25
26	Income Taxes and Illinois Personal Property Replacement Tax					26
	Nurse Aide Training for Non-Employees					27
	Yellow Page Advertising Other-Attach Schedule		/50 0nn			28 29
		0	(59,999)		0	
30	SUBTOTAL (A): (Sum of lines 1-29)	\$	(91,891)		\$	30

	OHF USE ONLY				
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$	3	31
32	Donated Goods-Attach Schedule*		3	32
	Amortization of Organization &			
33	Pre-Operating Expense		3	33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	242,557	3	34
35	Other- Attach Schedule	28,548	3	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 271,105	3	36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 179,214	3	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

Covenant Home of Chicago

ID#	0007914
Report Period Beginning:	02/01/00
Ending:	01/31/01

Sch. V Line

		SCII
NON-ALLOWABLE EXPENSES	Amount	Re

	NON ALLOWADIE EXPENSES			Scn. v Lin	
	NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Marketing/Fund Raising	S	(55,220)	43	1
2	Travel & Seminar		(3,094)	24	2
3	Promotion/Public Relations		(241)	20	3
4	Other Operating Revenue		(196)	21	4
5	Provider Participation Fee		28,548	42	5
6	Rent - Vehicles		(1,050)	35	6
7	Contributions Expense		(150)	21	7
8	Flowers		(48)	11	8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17		-			17
18		-			18
19		-			_
		_			19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43		-			43
44		-			44
45					45
46		-			46
47					47
48					48
49	Total		(31,451)		49

Summary A # 0007914 Report Period Beginning: Ending: 02/01/00 01/31/01

Facility Name & ID Number Covenant Home of Chicago

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D,	6E, 6F, 6G, 61	I AND 6I										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	1
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	224,126	0	0	0	0	0	0	0	0	0	224,126	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	224,126	0	0	0	0	0	0	0	0	0	224,126	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(48)	0	0	0	0	0	0	0	0	0	0	(48)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(48)	0	0	0	0	0	0	0	0	0	0	(48)	16
	C. General Administration													
17	Administrative	0	89,507	0	0	0	0	0	0	0	0	0	89,507	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(241)	0	0	0	0	0	0	0	0	0	0	(241)	20
21	Clerical & General Office Expenses	(346)	12,898	0	0	0	0	0	0	0	0	0	12,552	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,094)	0	0	0	0	0	0	0	0	0	0	(3,094)	
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(3,681)	102,405	0	0	0	0	0	0	0	0	0	98,724	28
	TOTAL Operating Expense			\Box										
29	(sum of lines 8,16 & 28)	(3,729)	326,531	0	0	0	0	0	0	0	0	0	322,802	29

STATE OF ILLINOIS Summary B

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/00 Ending: 01/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col	.7)
30	Depreciation	(29,745)	85,026	0	0	0	0	0	0	0	0	0	55,281	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,147)	0	0	0	0	0	0	0	0	0	0	(2,147)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(169,000)	0	0	0	0	0	0	0	0	(169,000)	34
35	Rent-Equipment & Vehicles	(1,050)	0	0	0	0	0	0	0	0	0	0	(1,050)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(32,942)	85,026	(169,000)	0	0	0	0	0	0	0	0	(116,916)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	28,548	0	0	0	0	0	0	0	0	0	0	28,548	42
43	Other (specify):*	(55,220)	0	0	0	0	0	0	0	0	0	0	(55,220)	43
44	TOTAL Special Cost Centers	(26,672)	0	0	0	0	0	0	0	0	0	0	(26,672)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(63,343)	411,557	(169,000)	0	0	0	0	0	0	0	0	179,214	45

0007914

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

A. Effect below the names of ALE owners and related organizations (parties) as defined in the instructions. Attach an additional schedule in necessary.										
1		2			3					
OWNERS		RELATED NURSING HO	OTHER REI	OTHER RELATED BUSINESS ENTITIES						
Name	Ownership %	Name	City	Name	City	Type of Business				
Covenant Ministries of Benevolence	100%	N/A		Swedish Cov. Hosp.	Chicago	Acute Pt. Care				
Covenant Retirement Communities, Inc	100%	See attached list	Various	Covenant Retire.	Chicago	Mgt. Co.				
				Communities, Inc.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

XX YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Scl	nedule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
1	V	6	Plant Ops, Maint. & Repair	\$	Swedish Covenant Hospital		\$ 224,126	\$ 224,126	1
2	V	30	Depreciation Expense		Swedish Covenant Hospital		85,026	85,026	2
3	V	21	Admin & General		Swedish Covenant Hospital	0.00%	12,898	12,898	3
4	V								4
5	V	17	Management Services	61,212	Covenant Retirement Communities, Inc.	100.00%	150,719	89,507	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 61,212			\$ 472,769	\$ * 411,557	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS]
#	0007914	Report Period Beginning:	02/01/00	Ending:

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01/31/01

VII.	REL	ATED	PARTIES	(continued)
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Facility Name & ID Number

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

XX YES NO

Covenant Home of Chicago

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
						Percent	Operating Cost	Adjustments for
Scho	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
						Ownership	Organization	Costs (7 minus 4)
15	V	19	Consulting Services	\$ 45,329	Covenant Retirement Communities, Inc.	100.00%	\$	\$ (45,329) 15
16	V		Detail:					16
17	V	19	Data Processing				5,328	5,328 17
18	V	19	Audit Services				2,582	2,582 18
19	V	19	Cost Report Preparation				3,000	3,000 19
20	V	19	Payroll Services				3,783	3,783 20
21	V	19	Medicare Consulting				26,411	26,411 21
22	V	19	Therapy Consulting				3,250	3,250 22
23	V	19	Other				975	975 23
24	V							24
25	V	22	Pension Plan Expense	19,314	Covenant Retirement Communities, Inc.	100.00%	19,314	25
26	V							26
27	V	34	Rent Expense	169,000	Swedish Covenant Hospital	0.00%		(169,000) 27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total			s 233,643			s 64,643	\$ * (169,000) 39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Covenant Home of Chicago # 0007914 Report Period Beginning: 02/01/00 Ending: 01/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		6	7		8	
						Average Hou	ırs Per Work				
					Compensation	Week Dev	oted to this	Compensati	on Included	Schedule V.	
					Received	Facility and % of Total		in Costs for this		Line &	
				Ownership	From Other	Work	Week	Reportin	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).

FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number	Covenant Home of Chicago	# 0007914	Report Period Beginning:	02/01/00	Ending: 01/31/01	

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	Covenant Retirement Communities, Inc.
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	5115 North Francisco Ave., Suite 200
or parent organization costs? (See instructions.) YES XX NO	City / State / Zip Code	Chicago, Illinois 60625
 -	Phone Number	(773) 878-2294
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	773) 878-2289

	1	2	3	4	5		6	7	8	9	T
	Schedule V		Unit of Allocation		Number of		Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being		Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among		Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	17	Management fees	Net Service Revenue	94,229,000	34	\$	4,976,952	\$ 1,813,264	1,158,931	\$ 61,212	1
2	19	Data Processing Service	Fixed Monthly Fee (1)	34	34		401,674	Not available	1	5,328	2
3	19	Audit Services	Fixed Monthly Fee (2)	34	34		208,612	0	1	2,582	3
4	19	Consulting Services	Fixed Monthly Fee (3)	14	14		61,464	0	1	3,000	4
5	22	Pension Plan Expense	Fixed Monthly Fee (4)	34	34		358,597	0	1	19,314	5
6	19	Payroll Services	Direct Cost	1	1		3,784	0	1	3,784	6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17		NOTE:									17
18		(1) Data processing services are a									18
19		(2) Auditing services are allocated				accou	ınt is adjusted at yea	r end to actual			19
20		(3) Consulting services are allocat									20
21		(4) Pension plan expense is allocate	ted based upon an estimat	ed fixed fee of \$1,609	.50 per month	<u> </u>					21
22											22
23											23
24											24
25	TOTALS					\$	6,011,083	\$ 1,813,264		\$ 95,220	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5		6	7	8	9	10	
	Name of Lender	Relate YES		Purpose of Loan	Monthly Payment Required	Date of Note		Amou Original	nt of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related	125	1,0		riequireu	11000		O'I'giiiiii	Dulanee		(Digita)	Zapense	
	Long-Term												
1	<u> </u>			N/A			\$		\$			\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6	Interco. Note To/From CRC	XX		Working Capital	O/S Balance			(2,331,133)	(131,886)			21,018	6
7													7
8													8
9	TOTAL Facility Related						s	(2,331,133)	\$ (131,886)			\$ 21,018	9
10	B. Non-Facility Related*			T	T	1					ı		10
11													11
12													12
13					 								13
13													13
14	TOTAL Non-Facility Related						\$		\$			\$	14
15	TOTALS (line 9+line14)						\$	(2,331,133)	\$ (131,886)			\$ 21,018	15

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0007914 Report Period Beginning: 2/1/2000 Ending: 1/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

B. Real Estate Taxes									
Real Estate Tax accrual used on 2000 report.	<i>Important</i> , please see the next worksheet, "RE_Tax". The bill must accompany the cost report.	real	estate tax statement and	\$	N/A	1			
1. Real Estate Tax decidal used on 2000 report.				Ф	14/71	 			
2. Real Estate Taxes paid during the year: (Indicate the	tax year to which this payment applies. If payment covers more than one y	ear, c	letail below.)	\$		2			
3. Under or (over) accrual (line 2 minus line 1).				\$	#VALUE!	3			
4. Real Estate Tax accrual used for 2001 report. (Deta	4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)								
11	as NOT been included in professional fees or other general operating costs less of invoices to support the cost and a copy of the appear			s		5			
6. Subtract a refund of real estate taxes. You must off classified as a real estate tax cost plus one-half of at TOTAL REFUND \$ For 1	y remaining refund.	peal	board's decision.)	\$		6			
7. Real Estate Tax expense reported on Schedule V, li	e 33. This should be a combination of lines 3 thru 6.			\$	#VALUE!	7			
Real Estate Tax History:									
Real Estate Tax Bill for Calendar Year: 199			FOR OHF USE ONLY						
199 199		13	FROM R. E. TAX STATEMENT FOR	2000	\$	13			
199 200		14	PLUS APPEAL COST FROM LINE 5	5	\$	14			
		15	LESS REFUND FROM LINE 6		\$	15			
		16	AMOUNT TO USE FOR RATE CALC	CULATIC	DN \$	16			

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	Covenant Home	of Chicago		COUNTY	Cook	
FAC	ILITY IDPH LICI	ENSE NUMBER	0007914				
CON	TACT PERSON I	REGARDING TH	IS REPORT				
TEL	EPHONE ()		FAX #: ()		
A.		al Estate Tax Cos					
	cost that applies t home property w	to the operation of hich is vacant, ren	l estate tax assessed for the nursing home in Co ted to other organizatio de cost for any period of	olumn D. Real on ns, or used for p	estate tax applicable ourposes other than	e to any poi	tion of the nursir
	(A))	(B)		(C)		(D)
3. 4. 5.			Property Descr		Total Tax \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	_	Tax Applicable to Nursing Home
6. 7		 -			\$		
8.					\$ \$	_	
9.					\$		
10.					\$		
В.	Deal Estate Tay	Cost Allocations		TOTALS	\$		
Б.		,	14				
	used for nursing		ly to more than one nur YES	sing nome, vac	ant property, or pro	perty wnici	is not direct
			chedule which shows the				ng hom

C. Tax Bills

 $Attach\ a\ copy\ of\ the\ 2000\ tax\ bills\ which\ were\ listed\ in\ Section\ A\ to\ this\ statement.\ Be\ sure\ to\ use\ the\ 2000\ tax\ bill\ which\ is\ normally\ paid\ during\ 2001.$

Page 10A

	ity Name & ID Number Covenant I JILDING AND GENERAL INFOR			# 0007914	Report Period Beginning:	02/01/00 Ending:	01/31/01
A.	Square Feet: 48,0	018 B. General Construction Type:	Exterior	Masonry Brick	Frame	Number of Stories	1
C.	Does the Operating Entity?	(a) Own the Facility	XX (b) Rent from	a Related Organization.		(c) Rent from Completely Unrel Organization.	ated
	(Facilities checking (a) or (b) mus	st complete Schedule XI. Those checking ((c) may complete Schedu	le XI or Schedule XII-A.	See instructions.	Organization.	
D.	Does the Operating Entity?	XX (a) Own the Equipment	XX (b) Rent equip	ment from a Related Or	ganization.	(c) Rent equipment from Compl Unrelated Organization.	letely
	(Facilities checking (a) or (b) mus	st complete Schedule XI-C. Those checkin	g (c) may complete Sche	dule XI-C or Schedule X	II-B. See instructions.	omente organization	
Е.	(such as, but not limited to, aparti	ned by this operating entity or related to a tments, assisted living facilities, day traini is, square footage, and number of beds/uni	ng facilities, day care, inc	dependent living facilitie			
F.	Does this cost report reflect any or If so, please complete the following	organization or pre-operating costs which	are being amortized?		YES	XX NO	
1.	Total Amount Incurred:			2. Number of Years Ov	er Which it is Being Amort	ized:	
3.	Current Period Amortization:			4. Dates Incurred:			
		Nature of Costs: (Attach a complete schedule de	tailing the total amount	of organization and pre-	operating costs.)		
XI. O	WNERSHIP COSTS:						
	A T and	1	<u>2</u>	3	4 Cont		
	A. Land.	Use	Square Feet	Year Acquired N/A	Cost	 	
		2		IVA	Ф	1 2	
		3 TOTALS			\$	3	

Page 11

0007914

Report Period Beginning:

02/01/00 Ending:

Page 12 01/31/01

Facility Name & ID Number Covenant Home of Chicago # 000.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar										
	1				4	3	6	/	8		
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		S	S	\$	4
5											5
6											6
7											7
8											8
	Impro	ovement Type**									
	N/A										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18 19											18
											19
20											20
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36				_					_		36

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

^{**}Improvement type must be detailed in order for the cost report to be considered complete

Page 12A 01/31/01 Facility Name & ID Number Covenant Home of Chicago # 0007

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment, (See instructions.) Round all numbers to nearest dollar # 0007914 Report Period Beginning: 02/01/00 Ending:

B. Building Depreciation-Including Fixed Equipment. (See inst	ructions.) Roui	id all numbers to nea	rest donar	, ,				
1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 N/A		\$	S		S	\$	S	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$	\$		S	\$	\$	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete

ÇТ	r A	TI	7 1	a	U	П	1	n	IN	1	١ī	C

		STATE OF ILLINOIS				Page 13
Facility Name & ID Number	Covenant Home of Chicago	# 0007914	Report Period Beginning:	02/01/00	Ending:	01/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	C. Equipment Depreciation Excitating Transportations (See instructions)											
	Category of	1	Current Book	Straight Line	4	Component	Accumulated					
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6					
71	Purchased in Prior Years	\$ 123,712	\$ 44,047	\$ 14,849	\$ (29,198)		\$ 67,010	71				
72	Current Year Purchases	10,944	1,094	547	(547)		547	72				
73	Fully Depreciated Assets	38,277					38,277	73				
74								74				
75	TOTALS	\$ 172,932	\$ 45,141	\$ 15,396	\$ (29,745)		\$ 105,834	75				

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	T = T
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	-	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

	E. Summary of Care-Related Assets	1	2		
		Reference	Amount]
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 172,932	81	1
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 45,141	82	1
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 15,396	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (29,745)	84]
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 105,834	85]

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	İ
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

^{**} This must agree with Schedule V line 30, column 8.

						STA	TE OF ILLINOIS						Page 14
Faci	lity Name & Il	D Number	Covenant Home of C	hicago		#	0007914	Report F	Period Beg	inning:	02/01/00	Ending:	01/31/01
XII.	1. Name of I 2. Does the f	nd Fixed Equ Party Holding	ay real estate taxes in addi	nant Hospit	al al amount shown below on	line	7, column 4? YES XX	NO					
		1	2	3	4		5	6					
		Year	Number	Date of	Rental		Total Years	Total Years					
	0	Constructe	ed of Beds	Lease	Amount		of Lease	Renewal Option*		10 Tree	1.4.6		
3	Original Building:	1977	52	02/01/77	\$ 169,000		Not available	N/A	3	Beginning	dates of curren	t rentai agreei	nent:
4	Additions	1977	34	02/01/77	3 105,000		Not available	IVA	4		Not Specified		
5	ridditions	_							5	Enuing	100 Specifica		
6									6	11. Rent to be	paid in future	years under t	he current
7	TOTAL		52		\$ 169,000				7	rental agr	eement:		
	This amou	unt was calcu ngth of the lea _	ortization of lease expense lated by dividing the total use N/A YES XX	amount to l			N/A N/A			Fiscal Year 12. 13. 14.	01/31/2002 01/31/2003 01/31/2004	Annual Re \$ N/A (will b) \$ N/A (will b) \$ N/A (will b)	e cost)
	15. Îs Moval	ble equipmen	Fransportation and Fixed t rental included in building ovable equipment:	ng rental?	(See instructions.) Description:		YES XX	NO e detailing the breake	lown of m	ovable equipme	ent)		
	C. Vehicle Re	ental (See inst	ructions.)				(5			,		
	1		2		3		4						
			Model Year		Monthly Lease		Rental Expense						
17	None Use		and Make	•	Payment	e	for this Period	17			is an option to rovide complet	•	0
18	None			J)		JP		18		schedule		e uctails on at	acticu
19							-	19		Scheduk	•		
20				1				20		** This am	ount plus any	amortization o	f lease

\$

21

expense must agree with page 4, line 34.

21 TOTAL

Facility Name & ID Number Covenant Home of	f Chicago				#	0007914	Report Per	iod Beginning:	2/1/2000	Ending:	1/31/2001
XIII. EXPENSES RELATING TO NURSE AIDE TRAINI	NG PROGRAMS	(See ins	tructions.)								
A. TYPE OF TRAINING PROGRAM (If aides are tra	ained in another f	acility p	rogram, attach a	schedule listing	the facilit	y name, addre	ss and cost pe	r aide trained in t	hat facility.)		
1. HAVE YOU TRAINED AIDES DURING THIS REPORT	YES	2.	CLASSROOM	PORTION:			3.	CLINICAL PO	ORTION:	_	
PERIOD?	XX NO		IN-HOUSE PE	ROGRAM				IN-HOUSE PR	OGRAM		
7011 11 11 11 11 11 11	IN OTHER FACILITY					IN OTHER FA	CILITY				
If "yes", please complete the remainder of this schedule. If "no", provide an			COMMUNITY	COLLEGE				HOURS PER A	AIDE		
explanation as to why this training was not necessary.			HOURS PER	AIDE							
B. EXPENSES	ALLO	OCATIO	N OF COSTS	(d)			C. CC	ONTRACTUAL IN			
	1		2	3		4	_	In the box below facility received			
	D	Faci	- J	Continue		T. (.)		6		_	
1 Community College Tuition	Drop-	-outs	Completed	Contract	e	Total		3			
2 Books and Supplies	3		,	3	J.		D NI	MBER OF AIDE	STRAINED		
3 Classroom Wages (a)							D.110	MIDER OF MIDE	S TRAINED		
4 Clinical Wages (b)				_				COMPLET	ΓED		
5 In-House Trainer Wages (c)								1. From this fac	cility		
6 Transportation								2. From other f	acilities (f)		
7 Contractual Payments								DROP-OU	TS		
8 Nurse Aide Competency Tests								1. From this fac	cility		
9 TOTALS	\$	9	3	\$	\$			2. From other f	acilities (f)	İ	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

TOTAL TRAINED

Page 15

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16 Report Period Beginning: 02/01/00 **Ending:** 01/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	(1	2	3	4	5	6	7	8	
		Schedule V	Stafi	Î	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other tl	nan consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	hrs	\$	647	\$ 27,174	\$	647	\$ 27,174	1
	Licensed Speech and Language									
2	Development Therapist	10a	hrs		15	630		15	630	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	hrs		133	5,660		133	5,660	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy	39	prescrpts		2,532		36,888	2,532	36,888	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					0				13
14	TOTAL			\$	3,327	\$ 33,464	\$ 36,888	3,327	§ 70,352	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

(last day of reporting year)

XV. BALANCE SHEET - Unrestricted Operating Fund.
This report must be completed even if financial statements are attached. As of 01/31/01

		1 O	perating	2 After Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	2,279	\$ 17,226,000	1
2	Cash-Patient Deposits		·		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		252,285	9,864,000	3
4	Supply Inventory (priced at)				4
5	Short-Term Investments			11,414,000	5
6	Prepaid Insurance			1,157,000	6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	254,564	\$ 39,661,000	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments			93,058,000	12
13	Land			17,382,000	13
14	Buildings, at Historical Cost			319,433,000	14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		77,787	41,970,000	16
17	Accumulated Depreciation (book methods)		(59,793)	(129,643,000)	17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds		42,234	39,505,000	21
22	Other Long-Term Assets (specify):			19,824,000	22
23	Other(specify): Construction in progress			46,224,000	23
	TOTAL Long-Term Assets			·	
24	(sum of lines 11 thru 23)	\$	60,228	\$ 447,753,000	24
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	314,792	\$ 487,414,000	25

		1 O	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	62,314	\$ 11,829,000	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits			8,139,000	28
29	Short-Term Notes Payable			3,685,000	29
30	Accrued Salaries Payable		125,107	5,053,000	30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		2,854		31
32	Accrued Real Estate Taxes(Sch.IX-B)				32
33	Accrued Interest Payable			1,621,000	33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Other acrued expenses		3,920	5,427,000	36
37	Resident and other current liabilities		3,144	5,900,000	37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	197,339	\$ 41,654,000	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable				40
41	Bonds Payable			197,962,000	41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43	Intercompany Accts, Other liabilities		(133,184)	8,529,000	43
44	Deferred Revenue			171,338,000	44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	(133,184)	\$ 377,829,000	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	64,155	\$ 419,483,000	46
	,		,	,	
47	TOTAL EQUITY(page 18, line 24)	\$	250,637	\$ 67,931,000	47
	TOTAL LIABILITIES AND EQUITY	Ý			
48	(sum of lines 46 and 47)	\$	314,792	\$ 487,414,000	48

^{*(}See instructions.)

Facility Name & ID Number | Covenant Home of Chicago | XVI. STATEMENT OF CHANGES IN EQUITY

Total Balance at Beginning of Year, as Previously Reported 288,818 Restatements (describe): 2 3 4 4 5 6 Balance at Beginning of Year, as Restated (sum of lines 1-5) 288,818 6 A. Additions (deductions): 7 NET Income (Loss) (from page 19, line 43) (38,181)7 8 Aguisitions of Pooled Companies 8 9 9 Proceeds from Sale of Stock 10 Stock Options Exercised 10 11 Contributions and Grants 11 12 12 Expenditures for Specific Purposes 13 Dividends Paid or Other Distributions to Owners 13 14 Donated Property, Plant, and Equipment 14 15 15 Other (describe) 16 Other (describe) 16 17 17 TOTAL Additions (deductions) (sum of lines 7-16) (38,181)B. Transfers (Itemize): 18 19 19 20 20 21 21 22 22 23 TOTAL Transfers (sum of lines 18-22) 23 24 BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) 250,637 24

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 2,518,702	1
2	Discounts and Allowances for all Levels	(702,250)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,816,452	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	556,701	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 556,701	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,865	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	36,226	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(689)	19
20	Radiology and X-Ray		20
21	Other Medical Services	132,274	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 174,676	23
	D. Non-Operating Revenue		
24	Contributions		24
	Interest and Other Investment Income***	2,147	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,147	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Benevolent Care	(176,807)	28
	Other Operating Revenue	196	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (176,611)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,373,365	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		420,678	31
32	Health Care		1,180,053	32
33	General Administration		474,589	33
	B. Capital Expense			
34	Ownership		237,029	34
	C. Ancillary Expense			
35	Special Cost Centers		99,197	35
36	Provider Participation Fee			36
	D. Other Expenses (specify):			
37				37
38	Rounding			38
39				39
40	TOTAL EVDENCES (compositions 21 through 20)*	6	2 411 546	40
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	2,411,546	40
41	Income before Income Taxes (line 30 minus line 40)**		(38,181)	41
	,		. , ,	
42	Income Taxes			42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	(38,181)	43

^{*} This must agree with page 4, line 45, column 4.

^{**} Does this agree with taxable income (loss) per Federal Income
Tax Return?

Yes If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Covenant Home of Chicago

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	(I his schedule must cover the	1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,840	2,210	\$ 56,505	\$ 25.57	1
2	Assistant Director of Nursing	1,816	2,129	41,618	19.55	2
3	Registered Nurses	13,868	15,680	264,165	16.85	3
4	Licensed Practical Nurses	5,441	6,106	86,582	14.18	4
5	Nurse Aides & Orderlies	35,928	42,691	402,893	9.44	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,389	1,555	41,832	26.90	7
	Rehab/Therapy Aides					8
9	Activity Director	960	1,066	16,726	15.69	9
10	Activity Assistants	2,386	2,651	30,947	11.67	10
11	Social Service Workers	1,432	1,668	22,478	13.48	11
12	Dietician					12
	Food Service Supervisor	1,760	2,049	31,637	15.44	13
	Head Cook					14
	Cook Helpers/Assistants	8,631	9,989	82,368	8.25	15
	Dishwashers					16
17	Maintenance Workers	678	780	9,206	11.80	17
	Housekeepers	6,315	6,774	54,714	8.08	18
	Laundry	506	596	4,966	8.33	19
	Administrator	1,162	1,408	48,352	34.34	20
	Assistant Administrator					21
	Other Administrative	1,152	1,263	20,411	16.16	22
	Office Manager					23
	Clerical	525	619	12,972	20.96	24
	Vocational Instruction					25
	Academic Instruction					26
	Medical Director					27
	Qualified MR Prof. (QMRP)					28
	Resident Services Coordinator					29
	Habilitation Aides (DD Homes)					30
	Medical Records	1,538	1,855	18,910	10.19	31
	Other Health Care(specify)	1,879	2,137	19,947	9.33	32
33	Other(specify) Marketing	512	567	8,195	14.45	33
34	TOTAL (lines 1 - 33)	89,718	103,793	\$ 1,275,424 *	\$ 12.29	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant	Monthly	\$ 6,390	1,3	35
36	Medical Director	Monthly	5,850	9,3	36
37	Medical Records Consultant	22	1,235	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,260	39,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	70	2,210	11,3	44
45	Social Service Consultant	15	750	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	107	s 17.695		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	603	11,848	10,3	52
53	TOTAL (lines 50 - 52)	603	\$ 11,848		53

^{**} See instructions.

STATE OF ILLINOIS			Page	Page 21	
4 0007014	Daniel Daniel Desiration	02/01/00	Endings	01/21/01	

Facility Name & ID Number Co	venant Home of C	Chicago			# 0007914		Repo	ort Period Begi	inning: 02/01/00 Endi	ng:	01/31/01	
XIX. SUPPORT SCHEDULES	-	-				_						
A. Administrative Salaries		Ownership)		D. Employee Benefits and Payro				F. Dues, Fees, Subscriptions and Promo	tions		
Name	Function	%		Amount	Description			Amount	Description		Amount	
Curtis, Rick	Administrator	0.00	\$_	23,038	Workers' Compensation Insura		\$_	17,136	IDPH License Fee			
Mueller, Barbara	Administrator	0.00	_	19,737	Unemployment Compensation I	nsurance	_		Advertising: Employee Recruitment		3,354	
			_		FICA Taxes		_	75,783	Health Care Worker Background Chec	<u>k</u>		
Fringe Benefits			_		Employee Health Insurance		_	130,018	(Indicate # of checks performed	_) _		
Curtis, Rick			_	2,814	Employee Meals		_		Dues & subscriptions		2,786	
Muella, Barbara			_	2,763	Illinois Municipal Retirement F	und (IMRF)*	_		Public Relations		241	
			_		Group Life Insuranc		_	6,045				
TOTAL (agree to Schedule V, line 1'	7, col. 1)				Pension Expense			19,314				
(List each licensed administrator sep	oarately.)		\$_	48,352	Reclass Administrators Benefit			5,577				
B. Administrative - Other					Unemployment taxes			39				
									Less: Public Relations Expense		(241)	
Description				Amount			_		Non-allowable advertising	_ (_		
Covenant Retirement Communities,	Inc.		\$	61,212					Yellow page advertising	_ ; _		
									1 2 2	_ ` _		
			_		TOTAL (agree to Schedule V,		\$	253,912	TOTAL (agree to Sch. V,	\$	6,140	
			_		line 22, col.8)		_		line 20, col. 8)	=		
TOTAL (agree to Schedule V, line 17, col. 3)				61,212	E. Schedule of Non-Cash Compensation Paid				G. Schedule of Travel and Seminar**			
(Attach a copy of any management s	ervice agreement)	_		to Owners or Employees							
C. Professional Services		,			,				Description		Amount	
Vendor/Pavee	Type			Amount	Description	Line#		Amount				
Deloitte & Touche, CPA's	Audit Services		S	2,582	Description	23110 11	S		Out-of-State Travel	\$	2,134	
ADP	Payroll Services		Ψ_	3,784			<u> </u>	-	Not allowable		(2,134)	
Covenenat Retirement Comm., Inc.	Data Processing		-	5,328			_		1100 4110 1140		(2,10.)	
Scutillo & Blake, CPA, PA	Cost Report Pre		-	3,000			_		In-State Travel		472	
FR&R Consulting	Billing Assistance		-	26,411			_		Not allowable		(472)	
Health Resource Alliance	Therapy Consul		-	3,250			_		110t anowabic		(472)	
Other	Therapy Collsul	ung	_	975			_					
Other			-	913			_		Seminar Expense		1,690	
			_		-		_		Out Of State Seminars			
			_				_				(420)	
			_				_		Board Member Travel		68	
			_			_	_		Not Allowable Board Member Travel	_ , -	(68)	
											١	
TOTAL (C. L. L. V. V.	0 1 2		_		TOTAL I		•		Entertainment Expense	_ ' _		
TOTAL (agree to Schedule V, line 19 (If total legal fees exceed \$2500 attac			_	45,330	TOTAL		\$_		(agree to Sch. V, TOTAL line 24, col. 8)	_ ' _ s	1,270	

^{*} Attach copy of IMRF notifications

^{**}See instructions.

Ending:

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year			Amount of Expense Amortized Per Year								
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	None												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

	y Name & ID Number Covenant Home of Chicago	#	0007914	Report Period Beginning:	02/01/00	Ending:	01/31/01
XX. G	ENERAL INFORMATION:						
(1)	Are nursing employees (RN,LPN,NA) represented by a union?	(13)		supplies and services which are of the Public Aid, in addition to the daily re			
(2)	Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. Life Services Network of III \$2,010		in the Ancillary Se	ction of Schedule V? Yes	_		
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A	(14)	the patient census is a portion of the b	building used for any function other listed on page 2, Section B? No building used for rental, a pharmacy, xplains how all related costs were all	day care, etc.)	For exampl If YES, attac	le,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A	(15)	Indicate the cost of on Schedule V. related costs?		ssified to employmeal income be the amount.	een offset ag	
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 10 Years	(16)	Travel and Transpo	ortation ncluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,714 Line 10		If YES, attach a	complete explanation. eparate contract with the Departmen	t to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.		program during c. What percent of	this reporting period. \$ N/A all travel expense relates to transporage logs been maintained? Adequa	tation of nurses	s and patients	
(8)	Are you presently operating under a sale and leaseback arrangement. No No No NA		e. Are all vehicles times when not	stored at the nursing home during the	e night and all	othei	
(9)	Are you presently operating under a sublease agreement? YES XX NO		out of the cost re	eport? Yes ty transport residents to and fr			No
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO XX If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over		Indicate the a	mount of income earned from p n during this reporting period.	providing suc		_
	N/A	(17)		performed by an independent certific	ed public accou		
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$\frac{28,548}{\text{V}}\$. This amount is to be recorded on line 42 of Schedule V.			that a copy of this audit be included Yes If no, please explain.	with the cost re		tions for the is copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.		out of Schedule V?				
		(19)	performed been att	re in excess of \$2500, have legal invached to this cost report? N/A d a summary of services for all archi		,	ices

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